An audit of subcutaneous syringe drivers in a non-specialist hospital.

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An Audit of Subcutaneous Syringe Drivers in a Non-Specialist Hospital

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The use of syringe drivers as a method of drug delivery to control symptoms in palliative care is a common and accepted practice, but one which has evolved rather than been subject to close multi-professional scrutiny and guideline formation. There is evidence that adverse incidents may arise as a result of syringe driver use (Medical Devices Agency (MDA) 1998), for example, errors in drug calculations, drug stability, equipment failure (including disconnection) and incorrect infusion rates. Inadequate user training, poor servicing of equipment and inadequate documentation and record keeping are all thought to be contributing factors (MDA 1998).

In the hospital where the audit was carried out (a district general hospital without specialist palliative care services), syringe drivers are used to administer drugs to patients with cancer during the palliative phase of illness. The purpose of this clinical audit was to establish the standard of current practice in wards where syringe drivers were being used. A retrospective study of 13 cases of syringe driver use is presented. The results highlight many areas of unregulated practice with regard to setting up, monitoring and maintenance of syringe drivers. The choice of drugs and dosage prescribed, evaluation of treatment responses and review of treatment regimens were also areas of concern. Guidelines for the use of syringe drivers in non-specialist hospitals are put forward.

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